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# Costs, Staffing, and Services of Assisted Living in the United States: A Literature Review

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**COSTS, STAFFING AND SERVICES OF ASSISTED LIVING IN THE USA: A  
LITERATURE REVIEW**

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# **COSTS, STAFFING AND SERVICES OF ASSISTED LIVING IN THE USA: A LITERATURE REVIEW**

## **ABSTRACT**

Assisted Living Facilities (ALFs), which provide a community for residents who require assistance throughout their day, is an important part of the long-term care system in the US. The costs of ALFs are paid either out of pocket, by Medicaid or by Long-Term Care Insurance (LTCI). Monthly costs of ALFs have increased over the past five years on an average of 4.1%. The purpose of this research was to examine the future trends in ALFs in the US to determine the impact healthcare on costs. The methodology for this study was a literature review and a total of 32 sources were referenced. Trends in monthly costs of ALF's have increased from 2004 to 2014. Within the past five years there has been an increase on average of 4.1% in assisted living costs. Medicaid is one payer for residents of ALF's while another alternative is the use of LTCI. Unfortunately, Medicare does not pay for ALF's. Staffing concerns in ALF's are limited due to each state having different rules and regulations. Turnover and retention rates of nurses in ALF's are suggested to be high while vacancy rate for nurses is suggested to be lower. The baby boomer generation can be one contribution to the increase in costs. Over the years there has been an increase in Alzheimer's disease which has had also an effect on cost in ALF's.

*Key Words: Assisted Living Facilities, ALF's, costs, residential care facilities, staffing, nurses*

## **INTRODUCTION**

Assisted living, also known as residential care, has been one of the fastest growing portions of the long-term care system in the United States (US) over the past several decades. From 1990 to 2002 the number of Assisted Living Facilities (ALFs) more than doubled in capacity and accommodated more than one million residents.<sup>1</sup> Between 2010 and 2050 the US is projected to

experience growth in the older population partly due to the baby boomers, a group which is expected to more than double in size during this time period.<sup>2</sup> As ALFs are state-regulated, oversight of these facilities varies widely.

These facilities are appropriate for individuals requiring long-term custodial and/or supportive care, but who do not require skilled nursing care.<sup>3</sup> According to the Assisted Living Federation of America (ALFA), assisted living is a long term care option that combines housing, support services and healthcare as needed, which notes that assisted living is designed for individuals who require assistance with everyday activities, also known as Activities of Daily Living (ADL).<sup>4</sup> Examples of ADLs include dressing, eating, bathing and transferring.<sup>5</sup> Approximately 38% of residents of ALFs receive assistance with three or more ADLs.<sup>6</sup> Additional services may include dining programs, educational activities, health services and medication administration, organized recreational activities, laundry services, etc. Most services are usually included in the facility's basic service costs, but some may be available only a-la-carte.<sup>7</sup>

Residents living in ALFs are more independent in comparison to nursing home residents. ALFs provide apartment style living to their residents which gives them a sense of self-sufficiency and privacy. Also, individuals moving into an ALF usually come directly from their own homes, so a transition to an apartment is much easier for them. Assisted living has been designed to allow residents dignity, privacy, autonomy, independence, choice and safety.<sup>8</sup>

ALFs can vary in size from smaller facilities with 4 to 10 beds to extra-large facilities with more than 100 beds.<sup>9</sup> The AHCA has pointed out that size of the facility is not as important as the services provided to the residents. About 82% of facilities are privately owned for profit and only 18% were private, nonprofit facilities.<sup>9</sup>

In 2007, the US had 1,046,631 total beds available in ALFs; by 2010 the number of such beds had risen nearly 18% to 1,233,690.<sup>10</sup> The market for ALFs has grown partly due to consumer needs - people requiring assistance with ADLs preferred to be cared for in ALF because it resembled a homelike setting.<sup>11</sup>

In 2010 the median Length of Stay (LOS) for residents in ALFs facilities was 671 days, with an estimated monthly cost of \$3165.<sup>6</sup> Most residents have been diagnosed with one or more chronic conditions such as hypertension, Alzheimer's and dementia osteoporosis, heart disease, depression, arthritis, diabetes.<sup>4</sup> The ALFA has classified resident characteristics in ALFs as 54% aged 85 or older, predominantly female, and 42% as having Alzheimer's and dementia.<sup>12</sup>

Patients with Alzheimer's disease can be a particular problem for assisted living facilities. Care for these patients has been characterized as particularly challenging.<sup>13</sup> Not only do the number of ADLs increase with progression of this disease), but this progression requires more and more highly trained staff.<sup>14</sup> In addition, Sonneman (2000), reported that these residents were not well-suited with the financial and operational restrictions of a classic assisted living facility.<sup>15</sup>

Individuals in ALFs require skilled care from trained professionals such as nurses, social workers, pharmacists, dieticians, physical therapists, occupational therapists, certified nurse assistants and nursing aides; the staff providing care has to be available 24 hours a day 7 days a week to meet the needs of the residents.<sup>16</sup> Approximately 40% of all ALFs provided some skilled care.<sup>17</sup> These facilities also employ other job positions such as administrators, marketing directors, housekeepers, dining staff, maintenance workers and activity coordinators.

The purpose of this research was to examine the future trends in ALFs in the US to determine the impact healthcare on costs.

## **METHODOLOGY**

The methodology for this qualitative study was a literature review. This study was conducted in three different steps: (1) identification of literature and collection of data (2) analysis of literature (3) categorization of literature.

### *Step 1: Identification and Collection of Literature*

Databases used for collection of literature included EBSCOhost, ProQuest, Academic Search Premier, CINHALL, PubMed, and Google Scholar. Also information from government websites were utilized and included the Center for Disease Control (CDC), Department of Health and Human Services (DHHS), AHCA, ALFA, and AHRQ for updated statistics and data for ALF's. Key words used were 'assisted living facilities' or 'residential care facilities' were combined with terms and 'cost' and 'staffing' and 'nurses' as inclusion to search only scholarly peer reviewed articles with full texts from databases.

### *Step 2: Analysis of Literature*

Literature was selected based on costs associated with ALF's and number of skill trained professionals working in ALF's in the US. Given the number of ALF's has increased in the past several years the costs associated was important. The search results were limited to those published between 2004 and 2014 in order to stay current with research and only written in English. Primary and secondary data were used from the literature written in the US only for this research. The references were evaluated and found to have satisfied the inclusion criteria if the information provided accurate data on ALF's. The literature search was conducted by AK and

validated by AC who was a second reader and reviewer of references provided that met the inclusion criteria. From a total of 385 initial references reviewed, 32 selected for this research study.

### *Step 3: Categorization of Literature*

Article abstracts were reviewed to decide the relevancy of the data for the study. If the articles and data were found relevant from the abstract they were evaluated and different categories were created based on the findings which include the trends in costs associated with assisted living, financial assistance available for residents of ALF's and the concerns with staffing in ALF's. The findings were presented in following section of the results: trends in costs associated with assisted living, financial assistance available for residents of ALF's and concerns with staffing in ALF's.

## **RESULTS**

### *Trends in Costs Associated With Assisted Living*

The mean costs associated with ALFs in the US rose steadily between 2004 and 2011, as seen in the Table, below. The monthly costs rose from \$2,524 in 2004 to \$3,500 in 2014. In 2006, the average monthly cost was \$2,968 in relation to \$2,969 in 2007.<sup>18</sup> Then in 2010 the cost was \$3,293 per month for a resident in comparison to \$3,477 per month for an AFL for 2011.<sup>19</sup> From 2010 to 2011 there was a calculated difference of \$184 per month increase which is a 5.3% increase. Between 2004 and 2011, the costs associated with assisted living facilities increased by 27.4%. (Table 1).

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Insert Table 1

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The costs associated with ALFs are not only associated with number and type of services required by each resident, but are also associated with the geographic region in which a facility is located.<sup>25</sup> Ten years prior to this study the state with the highest monthly cost was Connecticut where the mean cost of providing services in a ALF was \$4,327 per month, but that same year the costs of providing ALF services was only \$1,340 in Miami, Florida (Table 1).<sup>20</sup> In 2014, costs associated with ALFs in Washington DC averaged \$6,890 per month, while the average costs in Georgia and Missouri were \$2,500 per month.<sup>26</sup> The range of costs associated with ALFs in 2004 were \$1,340 to \$4,327; this range of average costs rose almost continuously until in 2014 was \$2,500 to \$6,890. This is a difference of \$1,160 from 2004-2014 for the lowest monthly costs and \$2,563 dollars for the highest monthly costs. These costs and cost ranges exclude services such as bathing assistance, dressing assistance and medication management which is an extra cost to residents, so actual, out-of-pocket costs to ALF residents are actually higher than reported in the Table, because these additional services are hardly optional for most residents of ALFs.<sup>24</sup>

#### *Financial Assistance Available For Residents of ALFS*

Most people believe that Medicare covers most long-term care services, but this is incorrect; Medicare pays only for skilled nursing facilities for the first 100 days.<sup>27,28,29,30</sup>

Medicaid is the major payer associated with ALFs in the US and between 2002 and 2009 the number of Medicaid participants increased by 43.9%.<sup>31</sup> However, the vast majority of the costs associated with ALFs are paid by the resident and his or her family.<sup>32</sup> In order to qualify for Medicaid, residents of ALFs must first virtually exhaust their assets to reach the Medicaid resource limit. Many enter an ALF as a “private pay” patient, paying for their care out of their



own pocket and then apply for Medicaid when they have spent down their savings to the point that they meet Medicaid's eligibility guidelines.<sup>33</sup>

Individuals may purchase Long Term Care Insurance (LTCI) to help pay for ALFs. The ALFA has suggested that LTCI is one of the best ways for an individual to afford to pay privately for ALFs, noting that experts suggest consumers should be looking for LTCI at age 40 and should have purchased it by age 50.<sup>30</sup> However, despite the fact that it is estimated that forty percent (70%) of the population over 65 will require long-term care services during their lifetime,<sup>34</sup> the public typically avoids any discussion of long-term care, because of the “fear and denial” associated with envisioning themselves in such a facility.<sup>35</sup> Those fears, and pre-existing health conditions which preclude insurers from issuing long-term care policies, combine to make private insurance for LTC “relatively uncommon”.<sup>36</sup> The dominant player in the traditional LTCI insurance market, Genworth Financial, recently acknowledged that it was continuing to struggle to remain profitable, a battle which the company has been waging for several years.<sup>37</sup> The price for LTCI is high, and growing. Finally, MacDonald (2011) stated that the main strain with LTC insurance has been that anybody who can afford it does not need it, and anyone who requires it cannot afford it.<sup>38</sup>

#### *Concerns with Staffing In ALFs*

Each state has different regulations concerning staff at ALFs.<sup>39</sup> The ALFA posts information regarding each state's assisted living regulations on staffing requirements through their website. For example, the state of Kentucky has defined that staffing shall be sufficient in number and qualification to meet the 24 hour schedule and unscheduled needs of its residents and the services provided, but Pennsylvania ALFs are required to have enough staff to provide at

least one hour of daily care to each resident needing personal care and two hours of assistance for patients who are immobile.<sup>40</sup> It was also reported that there are 18 states that set minimum staffing ratios; for example. Georgia and Mississippi require minimum staff to resident ratios of 1:15 during the day and 1:25 at night, while Alabama requires at least 1:8 staff to resident ratio during the day, 1:12 during the evening shift and 1:16 during the late night shift for specialty care ALF.<sup>40</sup> According to the US Government Accounting Office, consumers looking for ALFs need to check to see if the facility provides 24 hour service to care for the residents.<sup>41</sup>

In 2012 there were approximately 58,500 paid long term care providers that served eight million people in the US with the largest share of direct care workers as certified nursing assistants, personal care aides and home health aides. About two thirds of these providers provided care in residential settings such as nursing homes and assisted living facilities, and 19.2% or 143,600 full time equivalent nurses worked in residential care. The total average nursing hours for registered nurses, licensed practical nurses and aides per resident at a facility was 2.6 hours per day. The average nursing hours for licensed staff members was only 0.5 hours per resident, thus aides did the majority of the work in these facilities.<sup>42</sup>

The retention rate for nurses in ALFs in 2011 was 73%. This retention rate were defined and calculated by dividing the total number of employees who had worked in ALF for 12 months or longer by the total number of current employees. The vacancy rate for nurses in ALFs in 2011 was 3%, and was calculated by dividing the total vacant positions by total number of established positions. The turnover rate for nurses in ALFs in 2011 was high at 29%; this rate was calculated by dividing the total number of terminations by the total number of employees.<sup>43</sup>

## **DISCUSSION**

The purpose of this research was to examine the future trends in ALFs in the US to determine the impact healthcare on costs. It was also examined the number of trained professionals required to staff an ALF. The results suggest that costs will continue to increase over time and there are limitations on information concerning staffing in ALFs.

Individuals are growing older and living longer in today's society. In the US, the group of individuals aged 65 and older is rapidly growing and is projected to increase to 80 million by the year 2040. The baby boomer generation is a contributing factor to the increase. The number of individuals aged 85 and older will also continue to increase to 14 million by 2040.<sup>44</sup> Thus, ALFs are anticipated to continue to be an important component of the long-term care industry and the need for them is expected to increase due to the growth in the older population and its subsequent increasing need for healthcare of all kinds.

In regards to costs associated for residents in ALFs, the evidence demonstrates that the monthly costs have increased each and year from 2004 to 2012. The states with the highest and lowest monthly costs from 2004-2012 has also increased each year. Absent some major change in the payor system, the rise in costs of ALFs is anticipated to be an ever increasing barrier to the use of these facilities. Because assisted living costs vary widely in the US, as long as many individuals and families pay for ALFs out-of-pocket it is very important for consumers to compare prices of ALFs. It could be advantageous for individuals to go to a geographic location where ALF costs would be lower.

Size does matter in regards to costs with ALFs: increased spending for assisted living is associated with increased size of the facility. The smaller ALF's tend to offer fewer services to their residents in comparison to larger ALFs that tend to offer more services. These additional

services are not included in the base price and can become a financial burden to the residents who need them.

Another possible cause to increased spending is the health status of the resident in the ALF. If the resident exhibits a complex health condition he/she will require additional assistance during the day which will cost more. For example, patients with Alzheimer's disease and dementia require additional care that patients not having these conditions will pay more for their care. By the year 2050, there are estimated to be approximately 16 million Americans with Alzheimer's disease; cost of care for these individuals is estimated to be over \$1 trillion dollars.<sup>45,46</sup> ALFs may have Special Care Units (SCUs) for individuals who may have Alzheimer's disease or a related dementia diagnosis.<sup>47</sup> The ALFA suggest that these SCUs are staffed with trained professionals who are able to better care for these individuals and are housed in a special wing with additional security for the residents. These SCUs come at an added cost to the resident.

The costs of assisted living will continue to be financed either privately or federally through Medicaid. Private LTCI plays a very limited role in covering long-term care costs because of the high premiums associated with individuals purchasing.<sup>48</sup> Medicaid will remain the primary payer for ALFs unless a change occurs in government regulations of healthcare. Hosseini (2012) described that Obamacare has set aside \$20 billion over five years to encourage states to use Medicaid funds to help older people transition out of nursing homes to move to assisted living facilities. However, this represents only the tip of the iceberg considering the funding which would actually be required to solve the problem of paying for assisted living.<sup>49</sup>

According to Stevenson and Grabowski (2012), there are no national data on ALFs.<sup>11</sup> ALFs are regulated by each state and information regarding each state is vague in regards to the

number of individuals working in these facilities. Instead, each state gives staffing ratios for ALFs which does not give an accurate illustration of the number of employees in each ALF. Other limitations could have been the search strategy utilized, the amount of databases searched along with publication bias may have limited the articles that were identified for this study. Researcher bias could have restricted this study since the articles were assessed by the researcher as suitable for the study. Finally, there is insufficient reporting on the staffing associated with ALF's so it limited the references available.

Further research should be conducted to help determine if there will be adequate staffing available to residents in ALFs in order to keep up with the demand. There could be problems if there is not enough staff to adequately care for residents in ALFs. If there is inadequate staffing at these facilities it could cause quality of care issues and increased LOS contributing to increase spending by either the federal government or the resident of the ALF.

## **CONCLUSION**

Costs associated with ALFs are anticipated to continue to increase over the next several years based on the growth of the baby boomer population, larger sized ALFs and the increase in number of individuals with chronic health conditions. Costs, however, will vary widely from state to state and facility to facility. Consumers should strongly consider shopping among the many different ALFs available in their area, comparing both costs and services provided in order to determine which facility best meets their needs.

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Table 1: Monthly Assisted Living Costs including Highest and Lowest Costs in United States: 2004-2012

Source Year	Study Design	Mean Monthly Cost of Assisted Living (\$) (year over year % increase)	State with Highest Monthly Cost (\$)*	State with Lowest Monthly Cost (\$)*
MMMI 2004 <sup>20</sup>	MetLife market survey of assisted living costs	\$2,524	Connecticut (\$4,327)	Florida (\$1,340)
MMMI 2005 <sup>21</sup>	MetLife market survey of assisted living costs	\$2,905 (9.3%)		
MMMI 2006 <sup>22</sup>	MetLife market survey of assisted living costs	\$2,968 (2.1%)	New Jersey (\$5,197)	North Dakota (\$1,742)
MMMI 2007 <sup>18</sup>	MetLife market survey of assisted living cost	\$2,969 (0.0%)	Washington, DC (\$5,031)	Indiana (\$1,963)
MMMI 2010 <sup>23</sup>	MetLife market survey of long-term care costs	\$3,293 (9.8%)	Washington, DC (5,231)	Arkansas (\$2,073)
MMMI 2011 <sup>19</sup>	MetLife market survey of long-term care costs	\$3,477 (5.3%)	Washington, DC (\$5,757)	Arkansas (\$2,156)
MMMI 2012 <sup>24</sup>	MetLife market survey of long-term care costs	\$3,550 (2.1%)	Washington, DC (\$5,933)	Arkansas (\$2,355)

\*Data was not supplied by state in 2005